NOTE: **Self Insured Employer**
Complete this page on ALL reports.

Year Ending **December 31, 2004**

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site http://sip.dir.ca.gov
E-mail: sip@dir.ca.gov

PRIVATE SELF INSURER'S ANNUAL REPORT

I. GENERAL

1. CERTIFICATE NUMBER: ☐-☐☐☐☐-☐☐-☐☐☐

☐ Active ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year ☐ Interim/Amended Report for the Period of:

☐☐☐☐☐☐ (Month Day Year) to ☐☐☐☐☐☐ (Month Day Year)

3. NAME OF MASTER CERTIFICATE HOLDER:

NAME

ADDRESS

CITY STATE ZIP + 4

State of Incorporation: ☐☐

Federal Tax Identification No.:

First 4 Digits of Your North American Industry Classification System (NAICS): ☐☐☐☐

4. List names of ALL separate, but affiliated or subsidiary companies covered by this certificate (do not include DBAs or operating divisions):

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐
	☐☐	☐☐☐☐-☐☐

(Continue on reverse side of this page if necessary.)

5. During the reporting period of this report, has there been any of the following with respect to the Master Certificate Holder or any subsidiary?

(a) Reincorporating	☐ Yes	☐ No
(b) Merger	☐ Yes	☐ No
(c) Change in Identity	☐ Yes	☐ No
(d) Any additions to Self Insurance Program	☐ Yes	☐ No

If yes, explain:

(Continue on reverse side of this page if necessary.)

6. EMPLOYMENT AND WAGES PAID IN CALENDAR YEAR 2004:

(a) NUMBER OF EMPLOYEES
(For which a W-2 Tax Form was issued for California employment in Calendar Year 2004)

(b) TOTAL WAGES AND SALARIES PAID $
(As reported on EDD Form DE-6 Line M for all four quarters)

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE:

COMPANY NAME:

ADDRESS:

CITY: STATE: ZIP+4:

PHONE: ( ) FAX: ( )

E-MAIL ADDRESS:

SUBMIT TWO (2) COMPLETE REPORTS OF PAGES 1 THROUGH 5 INCLUDING LIST OF OPEN INDEMNITY CLAIMS

REPORT IS DUE MARCH 1, 2005

Note: This form is required to be submitted on 8 1/2 X 14-inch paper.

Form A4-40a (6/01)

Calendar Year 2004

4. (Continued)

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER
		-
		-
		-
		-
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		-
		-

5. (Continued)

Calendar Year

2004

NOTE: **Claims Administrator**
Complete a separate Page 2 for:
1. Each Claims Adjusting Office.
2. Each Self Insured Company merged into this Certificate within the last 4 years.
3. Each Self Insured Company posting a separate security deposit.

II. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: ☐-☐☐☐☐-☐☐-☐☐☐

Name/Identification of Location: _____

Name of Master/Subsidiary/Affiliate Certificate Holder: _____

Type of Report:

☐ Original Report (1/1/2004 to 12/31/2004) ☐ Amended Year End Report ☐ Amended Due to Audit ☐ Interim Report

From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1.Cases open as of 12/31/2004 reported prior to2000							
2. Open & Closed Cases:							
a. All cases reported in 2000							
2000 Cases open							
b. All cases reported in 2001							
2001 Cases open							
c. All cases reported in 2002							
2002 Cases open							
d. All cases reported in 2003							
2003 Cases open							
e. All cases reported in 2004							
2004 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4. Total Benefits paid during 2004 (including all case expenditures): . . . . . .

5. Number of MEDICAL-ONLY cases reported in 2004: . . . . . _____

6. Number of INDEMNITY cases reported in 2004: . . . . . _____

7. TOTAL of 5 and 6 (also entered in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in 2004: . . . . . _____

10. (a) Number of 2004 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2004: . . . . . _____

10. (b) Number of non-2004 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2004: . . . . . _____

11. Attach a List of *ALL* Open Indemnity Claims (by reporting location and by year) reported and with claims (in alphabetical order) immediately following page 5 of this report. (You may use the form attached or a computer-prepared printout organized in the same format.)

12. Attach the Specific Excess Insurance Policy page(s) 5.

Calendar Year 2004

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** _____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO**

IF YES: DATE OF CHANGE: ☐☐☐☐☐☐
Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**
☐ **Change to or from Self Administration**

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** _____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____
Original Signature of Administrator (Qualified Person) **Date**

_____ _____
Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____
Title **Street Address**

_____
City **State** **Zip+4**

Phone No. of Administrator ( ) _____ **Fax No. ( )** _____
area code **area code**

E-mail Address of Administrator _____

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III. ADMINISTRATOR INFORMATION

A. Number of Liabilities by Reporting Location Pages Submitted with this Annual Report _____

B. Identify the names of the Claims Administrators submitting each reporting location report and the Estimated Future Liability (Line 3) from each report:

1. Agency Name _____ **City** _____ **EFL $** _____

2. Agency Name _____ **City** _____ **EFL $** _____

3. Agency Name _____ **City** _____ **EFL $** _____

4. Agency Name _____ **City** _____ **EFL $** _____

5. Agency Name _____ **City** _____ **EFL $** _____

C. Total of Estimated Future Liability from all Reporting Location Pages $ _____

(Continue on reverse side, if necessary.)

IV. RECORDS STORAGE

1. Are claim records stored at any location other than with the current administrator?

☐ **Yes** ☐ **No** **If yes, Where?** _____

A. Agency Name _____ **B. Agency Name** _____

Address _____ **Address** _____

City _____ **State** ____ **Zip+4** _____ **City** _____ **State** ____ **Zip+4** _____

Phone (____ **)** _____ **Phone (** ____ **)** _____

(Continue on reverse side, if necessary.)

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:** _____

1. Name of Insurance Company: _____

Policy Number: _____ **Policy Issue Date:** _____

2. Name of Insurance Company: _____

Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____

Policy Number: _____ **Policy Issue Date:** _____

Retention Limit: _____

2. Name of Carrier: _____

Policy Number: _____ **Policy Issue Date:** _____

Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____

Policy Number: _____

Policy Issue Date: _____

Retention Limit: _____

2. Name of Carrier: _____

Policy Number: _____

Policy Issue Date: _____

Retention Limit: _____

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VI. DEPOSIT CALCULATION

A. Estimated Future Liability
(Sum of Line 3s, Estimated Future Liability, from all individual Liability Reports) . . . . . _____
(Page 3, Section III. C.)

(1) **Multiply by Deposit Factor** . . . . . **x 135%**

(2) Minimum Deposit Required . . . . . **$** _____

B. One Year Average Unpaid Claim Liability Calculation:

(1) Estimated Future Liability . . . . . **$** _____
(From Line A above)

(2) Less Future Liability of cases prior to 2000 . . . . . **- $** _____
(Sum of Future Liability [Medical and Indemnity]
from Line 1 of each report submitted)

Future Liability		
$ Indemnity	+	$ Medical

(3) Five year total unpaid Future Liability . . . . . **= $** _____

(4) One year average unpaid liability (Line 3 divided by 5) . . . . . **$** _____

C. Adjusted Deposit Required . . . . . **Subtotal $** _____
[Add Minimum Deposit Required to one year unpaid claim liability: Line A(2) + Line B(4)]

D. Adjustment for Specific Excess Coverage . . . . . **$** _____
(Insert credit for Specific Excess Coverage, if any, from Line 3 on Page 5 Reverse Side)

E. Security Deposit Required to be Posted (Line C minus Line D) . . . . . **$** _____
Note: Statutory Minimum Security Deposit is $220,000.

F. Total Security Deposit Currently Posted, All Types posted apart from alternative security program
(If you are fully participating in the alternative security program, indicate $0). . . . . **$** _____

Minimum Deposit Increase Indicated (Line E minus Line F) . . . . . **$** _____
Increase is Due by May 1.

Minimum Deposit Decrease Indicated (Line E minus Line F) . . . . . **$** **(** _____ **)**

NOTE: **Labor Code Section 3701(a) requires every private, self-insuring employer to secure incurred liabilities for the payment of compensation by renewing or making a new deposit of security within 60 days of filing of this annual report, but in no event later than May 1 of each year. Civil penalties of up to $5,000 for every 30 days or portion thereof that there is a failure to post deposit may be assessed by the Director of Industrial Relations pursuant to Labor Code Section 3702.9 for failure to post required deposit when due.**

CERTIFICATE OF COMPANY OFFICER

I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete. I am also aware of our company's duty to post and maintain the required security deposit that is due as a result of this report.

_____ _____
Signature of Company Officer **Date**

_____
Typed Name of Company Officer

_____
Title

_____
Name of Company

_____
Street Address

_____
City **State** **Zip+4**

_____
Phone No. ( )
area code

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SPECIFIC EXCESS INSURANCE POLICY COVERAGE

Certificate No: ______________________ **Name of Self Insurer:** ______________________________________

***Note:* Instructions to Claims Administrator—See Reverse Side of this Page.**

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Employer's Retention $:** **Upper Policy Limit $:**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: **$**

	Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "**b.**" is greater than "**a.**"
1 a.	$	**Minus b.**	$	= **c.**	$
	Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item **c.** above)		Total Unpaid Carrier Liability
2 d.	$	**Minus e.**	$	= **f.**	$

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Employer's Retention $:** **Upper Policy Limit $:**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: **$**

	Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "**b.**" is greater than "**a.**"
1 a.	$	**Minus b.**	$	= **c.**	$
	Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item **c.** above)		Total Unpaid Carrier Liability
2 d.	$	**Minus e.**	$	= **f.**	$

Name of Claimant	Claim No.	Date of Injury	First Year Reported **To SIP**
Description of Injury		Name of Specific Excess Carrier	
Policy Number	**Policy Period** **From:** **To:**	**Employer's Retention $:** **Upper Policy Limit $:**	

Claim Reported to Carrier? ☐ Yes ☐ No
Claim Acknowledged/Accepted by Carrier? ☐ Yes ☐ No
Has carrier denied any part or all liability of this claim? ☐ Yes ☐ No
Total of payment by excess carrier to date of this claim: **$**

	Employer's Retention		Total Paid on Claim (Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention Enter "0" if "**b.**" is greater than "**a.**"
1 a.	$	**Minus b.**	$	= **c.**	$
	Estimated Future Liability on Claim (From Indemnity & Medical figures from List of Open Indemnity Cases)		Unpaid Employer Retention (Item **c.** above)		Total Unpaid Carrier Liability
2 d.	$	**Minus e.**	$	= **f.**	$

SUBTOTAL Total Unpaid Carrier Liability This Page:

$ ____

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Instructions to Claims Administrator

Complete all the information requested on each claim that has estimated incurred liability greater than the minimum retention level of the specific excess insurance policy.

Add the subtotaled carrier liability for all pages necessary to list the claims in excess coverage and then complete the backside of this form on the last page of the specific excess insurance policy coverage pages in order to calculate the adjustment figure of Specific Excess Coverage to enter on Page 4, Line D of the Self Insurer's Annual Report.

Submit the completed page or pages as Item 12 of Section II, Liabilities by Reporting Location, for each Annual Report.

Note: You may use this form or a computerized form displaying the same information in the same format.

Calculation of Specific Excess Coverage Entry for Annual Report:

1. Total of Carrier Liability Listed on All Pages of "Specific Excess Insurance Policy Coverage" pages attached hereto: . . . . . $ _____

2. Enter Deposit Rate Applicable for This Self Insurer: . . . . . x _____

3. Multiply Line 1 by Line 2 and enter Specific Excess Insurance Adjustment: . . . . . $ _____

4. Enter Adjustment Figure on Line 3 above on Page 4, Line D.

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2004

LIST OF OPEN INDEMNITY CASES

AS OF_____

(Date)

Reporting Location No.: _____

All Cases on this Page are

For the Year _____

Certificate Number: _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			$ Indemnity	$ Medical	$ Indemnity	$ Medical
(List Alphabetically within year)						

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2004